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Medical Records Release

Patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_\_\_

Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_\_\_

**Responsible Party (Who can sign financial/legal documents):**

 Patient

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relation:  Spouse  Child  Guardian  Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**General authorization to release records to us:**

 I authorize any health care agency, laboratory, physician, or hospital to release any medical and/or insurance information regarding the above patient to Concierge Health & Rejuvenation Solutions and/or Nursing Home Physicians (or its assignees). The specific information requested will be attached to this general authorization, and shall be pertinent to the care of the aforementioned patient.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 (Printed name of responsible party) (Signature) (Relation)

**General authorization for us to release records to others:**

 Per federal law, neither this company nor its employees or owners or assignees will release any medical or financial information to any person or agency without the expressed written or witnessed consent of the responsible party designated above.

 I authorize Concierge HRS and /or Nursing Home Physicians (or its assignees) to release medical and/or insurance information to the following persons and agencies:

* My insurance carriers (or their designees) for the purpose of payment, audits, or reviews [no charge].
* My home health care agency for the purpose of medical care, payment, audits, or reviews [no charge].
* Medical personnel:  All medical personnel  Only those persons/agencies listed below

 [no charge under 20 pages]

* Family:  Any family member  Only those persons listed below [photocopying and postage charges apply]
* Any other person/agency listed below [prepaid photocopying and postage charges apply]:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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 (Printed name of responsible party) (Signature)

**General authorization for payment:**

* I authorize insurance payments to be made directly to the physician and that I am responsible for any balance.

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 (Printed name of responsible party) (Signature) (Relation)

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Telephone Authorization Exception

I, \_\_(Name)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, wish to be contacted in the following manner:

 **Home Work**

 Ok to leave detailed message on voicemail  Ok to leave detailed message on voicemail

 Leave message with call back number ONLY  Leave message with call back number ONLY

 **Cell Written Communications**

 Ok to leave detailed message on voicemail  Ok to fax information to:

 Secure Fax Number\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Leave message with call back number ONLY  Ok to email information to:

 Email Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

This permission to release information is effectively indefinitely or until Concierge Health and Medical Rejuvenation Solutions, LLC. Received notification from the patient of any changes regarding the release of information pertaining to their care under while under our care

Print name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Witness name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Witness Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_